IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

October 8, 2010

Thair Pond, Administrator
Tomorrow's Hope - Navarro
1655 Fairview Avenue, Suite 100
Boise, ID 83702

RE: Tomorrow's Hope - Navarro, Provider #13G061

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure survey of Tomorrow's Hope - Navarro, which was conducted on October 1, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner**:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or

other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **October 20, 2010,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by October 20, 2010. If a request for informal dispute resolution is received after October 20, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

JIM TROUTFETTER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/srm
Enclosures

TOMORROW'S HOPE, INC.
1655 FAIRVIEW AVENUE. SUITE 100
BOISE, ID 83702

PHONE: (208) 319-0760
FAX: (208) 319-0765

Jim Troutfetter
Health Facility Surveyor
Non Long Term Care
Bureau of Facility Standards
PO Box 83720
Boise, Idaho 83720-0009

18 October 2010

RE: Statement of Corrections for Navarro Survey

Dear Mr. Troutfetter.

Please find attached our Statement of Corrections for the deficiencies found during your recent survey of our Navarro ICF/ID.

Thank you for your team's professional approach to the survey. We consider the survey process and an important part of our Quality Assurance.

If you have any questions, please contact me at the above numbers.

Sincerely,
Thair Pond
Administrator

Incl
CC file, navarro

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G061	A. BUILDING _____ B. WING _____	10/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - NAVARRO	946 NORTHWEST 12TH MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Jim Troutfetter, QMRP, Team Leader Barbara Dern, QMRP Common abbreviations/symbols used in this report are: ABC - Antecedent Behavior Consequence ADHD - Attention Deficit Hyperactivity Disorder IDT - Interdisciplinary Team IPP - Individual Program Plan LPN - Licensed Practical Nurse PRN - As Needed PTSD - Post Traumatic Stress Disorder QMRP - Qualified Mental Retardation Professional SIB - Self Injurious Behavior	W 000	RECEIVED OCT 20 2010 FACILITY STANDARDS	
W 136	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. This STANDARD is not met as evidenced by: Based on observation, record review, and interviews with staff, it was determined the facility failed to ensure an individual was offered the opportunity to participate in social, religious, and community integration activities for 1 of 4 individuals (Individual #1) whose records were reviewed. This resulted in community integration opportunities being denied to the individual. The findings include:	W 136	W136 Individual's restrictive community program was Dc'd. Individual still had opportunity to go into community. Program was changed in which community access could not be taken away. PSRs to be completed on all restrictive components to include least restrictive identified and tried prior to the approval of the restrictive component. Program Director to review all restrictive programs All restrictive programs to be reviewed during monthly QA reviews and at least quarterly with new PSR ti be completed every 6 months Program Director responsible by 10/15/10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Thair Pond	Thair Pond, Administrator	10/18/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 136	Continued From page 1 1. Individual #1's IPP, dated 10/28/09, documented a 12 year old female diagnosed with PTSD, mood disorder, ADHD, and moderate mental retardation. Individual #1's Behavior Intervention Plan, dated 1/22/10, documented she earned community outings on a community participation reward scale. The Operational Definition of Target Behavior section stated, "Every seven days [Individual #1] can go up on her reward scale for "bigger" outings if she participated in the outings without maladaptive behaviors." This section further defined maladaptive behaviors as: - aggression toward staff, other clients, or other persons in the community. - eloping from staff. - aggressing on staff/driver in the van, weather [sic] van is driving or parked. - destroying property in the community setting/van. The Instructions for Intervention section defined the Community Participation Reward Scale as: - step 0: no outings. - step 1: small outings to the gas station with 2 staff. - step 2: outings to the dollar store or to a fast food restaurant for a snack with 2 staff. - step 3: outings with other individuals such as the park, dinner, or other planned group outings. Individual #1 needed to be successful in each step for 7 days prior to graduating to the next step. If Individual #1 engaged in behaviors, while on an outing, that put other clients or staff in danger she would be placed back on level zero. If at level zero, Individual #1 was not permitted to	W 136		

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W 136	Continued From page 2 attend any outings. When asked, the QMRP stated during an interview on 9/30/10 from 8:40 - 9:30 a.m., the restrictions were put in place after Individual #1 went on 3 outings and exhibited behaviors that endangered others. The QMRP stated she was only placed in step 0 as a result of her behavior on outings and her behavior in the home did not influence her outings. The facility failed to ensure that Individual #1 was offered opportunities to participate in community integration activities.	W 136		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavioral assessments were completed and contained comprehensive information for 2 of 4 individuals (Individuals #1 and #2) whose behavior assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #1's IPP, dated 10/28/09, documented a 12 year old female diagnosed with PTSD, mood disorder, ADHD, and moderate mental retardation. Individual #1's record documented she received Concerta (an attention deficit hyperactivity disorder drug) 54 mg daily for impulsivity,	W 214	W214 Behavior assessment will be updated including all areas and assessments looked at. Assessment will clearly define the function of all behaviors The assessment findings will be included in the development of the behavior plan All programs written to address maladaptive behaviors to be reviewed monthly with a PSR completed. The PSR to include the funtion of behavior Behavior plans to be reviewed prior to implementation and at least every 6 months at Monthly QA. Program Director responsible by 10/31/10	

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W 214	Continued From page 3 Trazodone (an antidepressant drug) 100 mg each night for sleep, Seroquel (an antipsychotic drug) 225 mg two times daily for agitation and aggression, and Prozac (an antidepressant drug) 20 mg in the morning for anxiety. Individual #1 also received a combination of Thorazine (an antipsychotic drug) 25 mg and Benadryl (an antihistamine drug) 25 mg as needed for agitation and aggression that could not be redirected. Individual #1's Functional Analysis Summary, dated 5/19/09, documented she engaged in cussing to seek attention. However, her Behavior Intervention Plan, dated 10/14/09, documented she engaged in eloping, aggression (hitting, kicking, biting, scratching, and spitting at staff and others), property destruction, and sexual aggression. However, Individual #1's record did not contain a behavioral assessment or information related to a description of the maladaptive behaviors, analyses of the potential causes, and the psychological, physiological, environmental, or social conditions which were eliciting and/ or sustaining the behaviors. When asked, the QMRP stated during an interview on 9/29/10 from 1:00 - 2:20 p.m., a behavior assessment was not completed to address all of Individual #1's maladaptive behaviors. The facility failed to ensure Individual #1's behavioral assessment was sufficiently developed and contained comprehensive information. 2. Individual #2's IPP, dated 4/22/10, documented	W 214		

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W 214	Continued From page 4 a 19 year old male diagnosed with Down's Syndrome, profound mental retardation, ADHD, and general seizure disorder. Individual #2's IPP documented he engaged in the following maladaptive behaviors: - Self-injurious behavior. - Pinching others. - Pulling others hair. - Self-stimulation of the genital area. Individual #2's record documented he received Trazodone (an antidepressant drug) 150 mg each night and Abilify (an antipsychotic drug) 10 mg each night. However, Individual #2's record did not contain a behavioral assessment or information related to a description of the maladaptive behaviors, analyses of the potential causes, and the psychological, physiological, environmental, or social conditions which were eliciting and/or sustaining the behaviors. When asked, the QMRP stated during an interview on 9/29/10 from 1:00 - 2:20 p.m., a behavior assessment was completed by a local psychologist. The QMRP stated a copy of this assessment could not be found and the assessment did not assess all of Individual #2's behaviors. The facility failed to ensure Individual #2's record contained a behavioral assessment.	W 214		
W 239	483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify provision for the	W 239		

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W 239	Continued From page 5 appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure appropriate replacement behaviors were identified and incorporated into the behavior management plan for 2 of 4 individuals (Individuals #1 and #2) whose behavioral interventions were reviewed. This resulted in individuals not receiving training to replace maladaptive behaviors. The findings include: 1. Individual #1's IPP, dated 10/28/09, documented a 12 year old female diagnosed with PTSD, mood disorder, ADHD, and moderate mental retardation. Individual #1's record included a Behavior Intervention Plan for "Problem solving/ eloping, aggression, property destruction, sexual aggression" dated 10/14/09, included a section titled Operation Definition of Target Behavior. This section documented Individual #1 engaged in the following maladaptive behaviors: - Eloping (defined as leaving the property, climbing the fence, or running out the front door) - Aggression (defined as hitting, kicking, biting, scratching, spitting, verbal aggression and name calling at staff and other individuals) - Property destruction (defined as breaking things, throwing objects at windows, and ripping books	W 239	W239 Individuals identified to be reviewed and updated to include an appropriate replacement behavior based upon the function of the behavior All programs written to address maladaptive behavior will be reviewed at the monthly behavior review meeting with a PSR completed to ensure the function of behavior has been identified and the replacement behavior is appropriate for the behavior being displayed. Behavior plans to be reviewed at Monthly QA and at least quarterly with a new PSR every 6 months QMRP responsible by 10/31/10	

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W 239	Continued From page 6 and papers) - Sexual aggression (defined as getting undressed and attempting to rub self on staff, trying to take staff's clothes off while rubbing self on them, becoming aggressive while trying to rub self on staff) The Behavior Intervention Plan also included an Objective section which stated that Individual #1 was to identify the problem. Additionally, her Functional Analysis Summary, dated 5/19/09, documented she engaged in cussing to seek attention. There was not a clear relationship between the function of the behavior and identifying the problem as the replacement behavior. When asked, the QMRP stated during an interview on 9/29/10 from 1:00 - 2:20 p.m., the replacement behavior was for Individual #1 to identify the problem and her feelings. The QMRP further stated, the replacement behaviors needed to be revised. 2. Individual #2's IPP, dated 4/22/10, documented a 19 year old male diagnosed with Down's Syndrome, profound mental retardation, ADHD, and general seizure disorder. Individual #2's record included an objective to decrease SIB to no more than 10 episodes per month. However, the record did not include information related to training he was to receive to appropriately replace his maladaptive behavior. When asked, the QMRP stated during an	W 239		

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W 239	Continued From page 7 interview on 9/29/10 from 1:00 - 2:20 p.m., a replacement behavior needed to be developed. The facility failed to ensure functional replacement behaviors were developed for Individuals #1 and #2.	W 239		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure data was collected to sufficiently to determine the efficacy of the intervention strategies for of 2 of 4 individuals (Individuals #1 and #2) whose behavior data was reviewed. Failure to document data consistently had the potential to impede the ability of the IDT in evaluating the effectiveness of programmatic techniques. The findings include: 1. Individual #1's and #2's records documented they displayed the following maladaptive behaviors: a. Individual #1 engaged in eloping (leaving the property, climbing the fence, or running out the front door), aggression (hitting, kicking, biting, scratching, spitting, verbal aggression and name calling at staff and other individuals), property destruction (breaking things, throwing objects at windows, and ripping books and papers), and sexual aggression (defined as getting undressed and attempting to rub self on staff, trying to take	W 252	W252 ABC forms were modified to include the effectiveness of the implementation plan All staff trained on how to fill out the ABC ABC will be reviewed monthly by Q to ensure staff are documenting the effectiveness of the behavior plan Behavior numbers and effectiveness of program to be presented at the monthly QA at least quarterly. QMRP Responsible by 11/15/10	

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W 252	Continued From page 8 staff's clothes off while rubbing self on them, becoming aggressive while trying to rub self on staff). b. Individual #2 engaged in self-injurious behavior, pinching others, pulling others hair, and self-stimulation of the genital area. Individual #1's and #2's ABC Forms were reviewed. The forms included a section for the date, start time, stop time, type of restraint, duration, target behavior, and a narrative section. In the narrative section, staff were to hand write what happened before, during, and after the behavior. The data was not accurate and comprehensive. Examples included but were not limited to the following: Individual #1's ABC Form, dated 8/1/10 from 3:30 - 3:39 p.m., documented that Individual #1 was upset that she could not go on an outing and threatened to beat up another child. It further stated staff explained the consequences to her. However, it did clearly state if the intervention was effective. Individual #1's ABC Form dated 3/14/10 from 8:00 - 8:10 p.m., documented that Individual #1 was watching television and staff prompted her that at 8:00 p.m. she needed to turn off the television. It stated the staff turned off the television at 8:00 p.m. and Individual #1 hit the staff, began stating that staff needed to stop bossing her around, and hit the staff one more time. It stated a second staff blocked her from hitting and was able to get her to calm down. However, the ABC Form did not clearly document	W 252		

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W 252	Continued From page 9 the intervention used to calm Individual #1. Individual #2's ABC Form, dated 9/8/10 from 6:20 - 6:35 p.m., documented that Individual #2 was playing with a mirror when the sun went behind a cloud. Individual #2 began to hit himself on the head 13 times and was redirected to another window. However, it was not clear how Individual #2 was redirected or if the redirection was successful. Individual #2's ABC Form, dated 5/10/10, documented that Individual #2 was walking around the house and hit his head. It stated he was redirected to toys. However, it did not document how many times he hit his head, what happened prior to him hitting his head, how he was redirected, or if the intervention was successful. Individual #2's ABC Form, dated 5/3/10 from 4:15 - 4:18 p.m., documented that Individual #2 was lying on the couch when he dropped to the ground and hit himself 36 times. It stated staff attempted to redirect him and he hit himself an additional 14 times. It further stated that he received Tylenol PRN. However, the ABC Form did not indicate if the Tylenol PRN was effective. Without comprehensive data regarding the antecedent events, the behavior, and the consequence of the behavior, it would not be possible for the facility to adequately assess whether or not the individuals' behavior intervention strategies were adequate. Further, the facility would not be able to identify what precipitated the behavior, what exact behavior occurred, whether or not the staff implemented the appropriate intervention, and whether or not	W 252		

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W 252	Continued From page 10 the intervention was effective. When asked, the QMRP stated during an interview on 9/30/10 from 8:40 - 9:30 a.m., the data was not comprehensive and the data collection needed to be revised. The facility failed to ensure data collected for individuals' maladaptive behaviors provided sufficient information to adequately assess the efficacy of the intervention strategies.	W 252		
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure an individual's record included evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive techniques to manage behavior for 1 of 4 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in the potential for an individual to be subjected to restrictive interventions unnecessarily. The findings include: 1. Individual #1's IPP, dated 10/28/09, documented a 12 year old female diagnosed with PTSD, mood disorder, ADHD, and moderate	W 278	W278 Refer to W136	

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W 278	Continued From page 11 mental retardation. a. Individual #1's Behavior Intervention Plan for community safety, dated 1/22/10, documented she earned community outings on a community participation reward scale. The Operational Definition of Target Behavior section stated, "Every seven days [Individual #1] can go up on her reward scale for "bigger" outings if she participated in the outings without maladaptive behaviors." This section further defined maladaptive behaviors as: - aggression toward staff, other clients, or other persons in the community - eloping from staff. - aggressing on staff/driver in the van, weather [sic] van is driving or parked - destroying property in the community setting/van. The instructions for Intervention section defined the Community Participation Reward Scale as: - Step 0: no outings. - Step 1: small outings to the gas station with 2 staff. - Step 2: outings to the dollar store or to a fast food restaurant for a snack with 2 staff. - Step 3: outings with other individuals such as the park, dinner, or other planned group outings. Individual #1 needed to be successful in each step for 7 days prior to graduating to the next step. If Individual #1 engaged in behaviors, while on an outing, that put other clients or staff in	W 278		

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	13G061	A. BUILDING _____ B. WING _____	10/01/2010

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W 278	Continued From page 12 danger she would be placed back on level zero. The Least Restrictive Interventions Used section documented her prior placement had used escorts, she had been admitted to a local psychiatric hospital, emergency restraints had been put in place, and restrictive programming had been put in place. There was no documentation of interventions tried by the facility. Further, there was no documentation of less restrictive interventions being tried and proven ineffective to manage her behavior on community outings prior to restricting her access to community outings. When asked, the QMRP stated during an interview on 9/30/10 from 8:40 - 9:30 a.m., the restrictions were put in place after Individual #1 went on 3 outings and exhibited behaviors that endangered others. She further stated, no other interventions were implemented; however, she believed a token reinforcement system had been tried. The facility failed to ensure less restrictive interventions were first tried and found ineffective prior to implementing more restrictive, less positive interventions for Individual #1.	W 278		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.	W 289		

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W 289	Continued From page 13 This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently defined and incorporated into the program plans for 1 of 3 individuals (Individual #2) whose program records were reviewed. This resulted in a lack of appropriate interventions being in place to ensure an individuals behavioral needs were met. The findings include: Individual #2's IPP, dated 4/22/10, documented a 19 year old male diagnosed with Down Syndrome, profound mental retardation, ADHD, and general seizure disorder. His IPP contained an objective stating Individual #2 would decrease SIB to no more than 10 episodes per month. However, his IPP did not contain a program that addressed SIB. When asked, the QMRP stated during an interview on 9/29/10 from 1:00 - 2:20 p.m., Individual #2 did not have a Behavior Intervention Plan related to SIB. The facility failed to ensure plans were developed to address Individual #2's SIB.	W 289	W289 Individual has a behavior plan to address SIB completed by 10/13/10 IPP objectives to be checked with program book to ensure there is a plan in place for all indentified priority needs. Record review form to be filled out quarterly with any missing programs to be added to the action list for items to be completed Program Director responsible by 11/15/10	
W 382	483.460(I)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by:	W 382		

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W 382	Continued From page 14 Based on observation and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions. This failure directly impacted 7 of 7 individuals (Individuals #1 - #7), residing in the facility. This resulted in the potential for harm in the event individuals accessed and ingested a drug. The findings include: 1. On 9/28/10 at 2:10 p.m., an unlocked file drawer located in the QMRP's office was noted to contain 51 blister packs of drugs. The office had two doors with two locks on each door. The doors were noted to be opened throughout the day and staff members were noted to go through the office when going on breaks and when leaving or arriving to work. The drugs in the unlocked file drawer included but were not limited to the following: - A blister pack containing 31 tablets of Abilify (an antipsychotic drug). - A blister pack containing 31 tablets of Seroquel (an antipsychotic drug). - A blister pack containing 31 tablets of Risperidone (an antipsychotic drug). - A blister pack containing 31 tablets of Depakote (an antiepileptic drug). - A blister pack containing 31 tablets of lorazepam (an antianxiety drug). - A blister pack containing 31 tablets of alprazolam (an antianxiety drug).	W 382	W382 Maintenance immediately installed a second medication cabinet that met requirements A double lock was installed for the storage of the next months medications Medication storage will be checked on monthly house PSR to ensure there is enough storage for the next months medications. Staff training completed to ensure staff know all medications are locked. Spot checks will be reviewed at the monthly QA QMRP responsible by 11/15/10	

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W 382	Continued From page 15 - A blister pack containing 31 tablets of Trazodone (an antidepressant drug). - A blister pack containing 31 tablets of Remeron (an antidepressant drug). - A blister pack containing 31 tablets of levothyroxine (a thyroid drug). When asked during an interview on 9/28/10 from 2:10 - 2:43 p.m., the QMRP, who was present, stated she was unaware the file cabinet that contained the drugs had to be locked as there were locks on the office door. The nurse, who was also present, stated there was no place in the facility where the drugs could be locked. The nurse inventoried the drugs at 2:41 p.m. on 9/28/10 and stated all drugs were accounted for. The nurse left the facility with the drugs at 2:43 p.m. on 9/28/10. 2. During an environmental assessment conducted on 9/28/10, from 11:25 a.m. - 12:00 p.m., a cabinet in the laundry room containing various PRN medications was noted to be unlocked. The QMRP, who was present stated the cabinet should have been locked and directed a staff member to secure the medications. The facility failed to ensure all medications were kept secured when not in use.	W 382		

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MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W289.	MM197	MM197 Refer to W289	
MM207	16.03.11.075.13 Freedom of Association Freedom of Association. Each resident admitted to the facility must be permitted to associate and communicate privately with persons of his choice, and to participate in activities of social, religious, and community groups at his discretion, unless medically contraindicated as documented by his physician in his medical record. This Rule is not met as evidenced by: Refer to W136.	MM207	MM207 Refer to W136	
MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W252.	MM212	MM212 Refer to W252	
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all toxic	MM271	RECEIVED OCT 20 2010 FACILITY STANDARDS	

Bureau of Facility Standards

Thair Pond, Administrator 10/18/10
TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Facility Standards

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MM271	Continued From page 1 chemicals were stored under lock and key for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the potential for individuals to have access to toxic chemicals. The findings include: 1. During an environmental review on 9/28/10 from 11:20 a.m. - 12:00 p.m., the following toxic chemicals were found to be unlocked: - Two 1 gallon containers of windshield wiper fluid. - One 1 gallon container of carpet cleaner. The QMRP, who was present, stated the chemicals should have been locked. The QMRP then directed a staff member to secure the chemicals. The facility failed to ensure all hazardous chemicals were kept secured when not in use.	MM271	MM271 Identified chemicals immediately stored correctly. Staff to be trained on the proper storage of hazardous materials. QMRP to inspect home regularly to ensure proper storage maintained. PSR of home listing storage to be reviewed at QA. QMRP responsible by 11/01/10	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the environment being kept in	MM380	MM3809 All identified deficiencies will be cleaned, replaced, repaired as needed to ensure compliance with requirements. QMRP and maintenance responsible by 11/15/10	

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MM380	Continued From page 2 ill-repair. The findings include: An environmental review was conducted on 9/28/10 from 11:25 a.m. - 12:00 p.m. During that time, the following was noted: Dining Room: - The right leaf of the dining table had broken bottom rails on both sides. Living Room: - The couch by the kitchen wall had stains on both arms approximately six inches by twelve inches. - The back cushions of the couch by the kitchen wall were stained and soiled. - The seat cushions of the couch by the kitchen wall were stained and soiled. - The couch in front of the front door had a 4 inch rip in the left arm along the wood trim. - The right seat cushion of the couch in front of the front door and a 3 inch diameter stain. - The top of the seat back of the couch in front of the front door had a 4 inch by 4 foot stain. - The right arm of the couch in front of the front door had two 3 inch long stains. - The couch below the windows had stains throughout the seat cushions and back cushions. - The wall to the right of the right window looking into the backyard there was a 1 1/2 foot by 1 1/2 foot patch with no paint. - Above the couch by the kitchen wall there was a 1 foot by 1 foot patch with no paint. Bedroom Hallway: - There was a 1 1/2 foot by 1 1/2 foot patch with no paint, which included a 3 inch by 1 inch section of exposed drywall, on the wall between the living room and the hallway. - The wall next to Individual #1's room contained	MM380		

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MM380	Continued From page 3 a 1 foot by 1 1/2 foot patch with no paint. Individual #3's and #7's bedroom: - The wall between the door and the closet had a 10 inch diameter patch with no paint and a 6 inch diameter whole in the center. Individual #1's bedroom: - The floor was cluttered with toys, clothes, shoes, and purses causing a trip hazard. - There was a toy guitar and a shoe on the stairs to her bed causing a trip hazard. - The top drawer of the dresser next to the closet was missing. Entryway: - There was a 1 foot by 1 1/2 foot patch with no paint on the right side. Hallway by laundry room: - There was a 1 foot by 2 foot patch with no paint between the laundry room and Individual #4's and #5's bedroom. - On top of the kitchen doorway there was a 1 foot by 1 foot patch with no paint. - To the right of the kitchen doorway, near the bottom, there was a 1 foot by 3 foot patch with no paint. Bathroom in Individual #4's and #5's bedroom: - There was calking missing around the toilet. - The sink was slow to drain. - There was a 1 1/2 foot by 3 foot patch with no paint between the shower and closet. - In front of the shower there was a 3 foot by 1 1/2 foot section of flooring that was uneven and cracking. Backyard: - The trampoline did not have a cover over the	MM380		

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MM380	Continued From page 4 springs. - The playhouse was unstable and shook from side to side. - The second board up on the left side of the playhouse was falling off. The facility failed to ensure environmental repairs were maintained.	MM380		
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730	MM730 Refer to W214	
MM753	16.03.11.270.02(f)(i) Locked Area All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by: Refer to W382.	MM753	MM753 Refer to W382	
MM855	16.03.11.270.08(c) Training and Habilitation Record There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W239.	MM855	MM855 refer to W239	